skai BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 50
Little Rock, AR 72203-1460

# CHANGE FORM

## Section 1: Employment and Coverage Information

| Name of Employer | Name of Employee | | Social Security # | Division # |
|---|---|---|---|---|
| | Last Name | First Name | - - | |

## Section 2: Employee Information

| Type of Change | Current | Change | Effective Date |
|---|---|---|---|
| ☐ Name change | | | |
| ☐ Address change | | | |
| ☐ Change in type of coverage and/or division # change | ❑ Single Medical ❑ Family Medical<br>❑ Single Dental ❑ Family Dental<br>❑ Single COBRA ❑ Family COBRA<br>❑ Other_____<br>Division # _____ | ❑ Single Medical ❑ Family Medical<br>❑ Single Dental ❑ Family Dental<br>❑ Single COBRA ❑ Family COBRA<br>❑ Other_____<br>Division # _____ | |

❑ Termination of contract – Termination Date _____

## Section 3: Dependent Information

| Add* | Drop | Date of Add/Drop | Last Name | First Name | MI | Birth Date Mo/Day/Yr | Sex M/F | Dependent Social Security # | Relationship to Employee | Full-time Student ✓ | Handi-Capped ✓ | Selected PCN Physician (if applicable) | Employer Use Only: Pre-ex condition excluding exp. date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ❑ | | | | | | | - - | | | | | |
| ☐ | ❑ | | | | | | | - - | | | | | |
| ☐ | ❑ | | | | | | | - - | | | | | |
| ☐ | ❑ | | | | | | | - - | | | | | |
| ☐ | ❑ | | | | | | | - - | | | | | |

*If you are adding a dependent who has other insurance, complete the following:

Policyholder's Name _____ Policyholder's Relation to Dependent _____ Policyholder's Date of Birth _____

## Section 5: Other — List any other requested changes in enrollment information.

## Section 6: Signature (Please read before signing in ink)

**In signing below, I represent that the statements and answers given on this form are true, complete and correctly recorded to the best of my knowledge and belief.**

Signature of Applicant _____ Date _____ Employer/Group Representative Verification _____ Date _____